PARENT/GUARDIAN TO COMPLETE

THE FOLLOWING INFORMATION MUST BE PROVIDED OR CLAIM CANNOT BE PROCESSED
INSTRUCTIONS ON REVERSE SIDE/PLEASE LEAVE NO BLANK LINES/PLEASE DO NOT INDICATE N/A

STUDENT NAME: _____ DATE OF ACCIDENT: _____

FATHER	MOTHER
FULL NAME _____	FULL NAME _____
SOCIAL SECURITY NUMBER _____	SOCIAL SECURITY NUMBER _____
HOME PHONE(____) _____ BUSINESS PHONE (____) _____	HOME PHONE(____) _____ BUSINESS PHONE (____) _____
EMPLOYER _____	EMPLOYER _____
EMPLOYER ADDRESS _____	EMPLOYER ADDRESS _____
PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED	PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED
YES ☐ NO ☐	YES ☐ NO ☐
DOES YOUR EMPLOYER PROVIDE GROUP INSURANCE? ☐ ☐	DOES YOUR EMPLOYER PROVIDE GROUP INSURANCE? ☐ ☐
DO YOU SUBSCRIBE: ☐ ☐	DO YOU SUBSCRIBE: ☐ ☐
DO YOU SUBSCRIBE TO AN INDIVIDUAL PLAN? ☐ ☐	DO YOU SUBSCRIBE TO AN INDIVIDUAL PLAN? ☐ ☐
DOES YOUR PLAN OFFER DEPENDENT COVERAGE? ☐ ☐	DOES YOUR PLAN OFFER DEPENDENT COVERAGE? ☐ ☐
IS THIS STUDENT COVERED BY YOUR PLAN? ☐ ☐	IS THIS STUDENT COVERED BY YOUR PLAN? ☐ ☐
INDIVIDUAL ☐ GROUP POLICY ☐ HMO/PPO ☐	INDIVIDUAL ☐ GROUP POLICY ☐ HMO/PPO ☐
NAME OF INSURANCE/PLAN _____	NAME OF INSURANCE/PLAN _____
MAILING ADDRESS _____	MAILING ADDRESS _____
CITY/STATE/ZIP _____	CITY/STATE/ZIP _____
TELEPHONE NUMBER (____) _____	TELEPHONE NUMBER (____) _____
CERTIFICATE/POLICY # _____	CERTIFICATE/POLICY # _____
GROUP # _____	GROUP # _____
AMOUNT OF DEDUCTIBLE _____	AMOUNT OF DEDUCTIBLE _____
If you are employed, but your dependent is not covered under your employer's plan, a letter of this effect from your employer is required.	If you are employed, but your dependent is not covered under your employer's plan, a letter of this effect from your employer is required.

I HEREBY AUTHORIZE STUDENT ATHLETIC PROTECTION, INC. OR ITS REPRESENTATIVES TO SECURE OR INSPECT COPIES OF CASE HISTORY RECORDS, LABORATORY REPORTS, DIAGNOSES, PROGNOSES, X-RAY AND ANY OTHER DATA COVERING THIS/PREVIOUS CONFINEMENTS/DISABILITIES. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE DEEMED AS EFFECTIVE AND VALID AS THE ORIGINAL FOR **TWO YEARS** AFTER SIGNING. DRAFTS FOR ANY BENEFITS ASSIGNED WILL AUTOMATICALLY BE SENT TO THE HOSPITAL, DOCTOR, OR OTHER SUPPLIER OF MEDICAL SERVICES UNLESS I SUBMIT A SIGNED STATEMENT REQUESTING THAT PAYMENT BE MADE TO SOMEONE ELSE. I SHALL PROVIDE RECEIPTS/CANCELLED CHECKS SHOWING PAYMENTS I HAVE MADE IF I REQUEST THAT PAYMENT BE MADE TO ME. I FULLY REALIZE THAT THIS PROGRAM IS BASED ON PAYMENT OF BILLS INCURRED WITHIN ONE YEAR FROM THE DATE OF ACCIDENT, WITH COVERAGE ONLY IN EXCESS OF ALL OTHER INSURANCES/PLANS WHICH MUST CONTRIBUTE THEIR MAXIMUMS FIRST. I FURTHER STATE THAT WE HAVE ALREADY PRESENTED THIS CLAIM TO OUR INSURANCE OR PLAN, AND WE ARE ATTACHING TO THIS CLAIM FORM ITEMIZED BILLS AND EVIDENCE OF BENEFITS PAID OR COPY OF A DENIAL OF BENEFITS LETTER FROM OUR INSURANCE/PLAN.

SIGNATURE _____ ADDRESS _____

SCHOOL OFFICAL TO COMPLETE

1. NAME OF SCHOOL _____
2. STUDENT'S FULL NAME (PRINT): LAST _____ FIRST _____ M.I.: _____ SEX: _____ GRADE: _____
3. STUDENTS HOME ADDRESS; _____ CITY _____ STATE _____ ZIP _____
4. DATE OF ACCIDENT: MONTH _____ DAY _____ YEAR _____ HOUR _____ A.M. OR P.M.
5. DETAILED DESCRIPTION OF ACCIDENT; HOW DID IT OCCUR? (OR ATTACH ACCIDENT REPORT COMPLETED BY THE SCHOOL REPRESENTATIVE WHO WITNESS ED THE ACCIDENT) _____
6. WHERE DID IT OCCUR? _____
7. PART OF BODY INJURED; RIGHT ☐ LEFT ☐ PART: _____
8. ACTIVITY OR SPORT _____
   OTHER (DESCRIBE) _____
9. HAS A CLAIM EVER BEEN FILED WITH STUDENT ATHLETIC PROTECTION, INC. ON THIS STUDENT? YES _____ NO _____
10. NAME OF SCHOOL AUTHORITY SUPERVISING ACTIVITY: _____
11. WAS SUPERVISOR A WITNESS TO THE ACCIDENT? YES _____ NO _____
12. IF NOT, WHEN WAS THE ACCIDENT FIRST REPORTED TO A SCHOOL AUTHORITY? DATE: _____
13. TYPE OF SCHOOL THE STUDENT ATTENDS: ELEMENTARY ☐ JR. HIGH ☐ SR. HIGH ☐ COLLEGE ☐
14. SIGNATURE OF SCHOOL OFFICIAL _____ TITLE: _____

DATE OF THIS REPORT _____

ROCHESTER COMMUNITY SCHOOLS ACCIDENT COVERAGE

Dear Parent/Guardian:

Rochester Community Schools provides accident coverage for all school supervised and sponsored activities. Outlined below are important elements of this coverage. This is a brief description of the coverage and is not the policy. The school holds the policy.

This coverage is for medical bills resulting from ***ACCIDENTS*** only. An accident is defined as an unexpected, sudden and definable event, which is the direct cause of a bodily injury, independent of any illness or congenital predisposition.

Conditions that result from participating in sports do not necessarily constitute an accident. Illnesses, diseases, degeneration and conditions caused by continued stress to a particular area of the body, and existing conditions aggravated or exacerbated by an accident are not covered.

This plan is excess coverage and payment is made only after the primary carrier has made payment. ***If you are a member of an HMO/PPO, the proper procedures outlined by that plan must be followed before this coverage has any liability***.

Treatment by a licensed practitioner of medicine must begin within **60 days** of the accident. Only expenses incurred within **52 weeks** of the date of the original accident are considered. Benefits are determined by **REASONABLE AND NECESSARY** charges for the geographic region.

Exclusions include, but are not limited to: sickness, disease or hernia in any form, non-prescription drugs, fighting, the use of electric bio-mechanical devices, and orthotics not prescribed exclusively for rehabilitation (e.g. playing brace, mouth guard).

Accidents must be reported *within twenty days* to the school. Claim forms should be submitted to Student Athletic Protection, Inc. within *ninety days* after treatment ends, but **never later than fifteen months after the date of the accident**. Questions regarding claims should be directed to Student Athletic Protection, Inc., 3207 Stadium Dr. Suite #7, Kalamazoo, MI 49008-1500 or call 1-800-232-1579. Student Athletic Protection, Inc. administers the coverage, which is underwritten by Guarantee Trust Life Ins. Co.

HOW TO FILE YOUR ACCIDENT CLAIM FORM

1. Complete ALL blanks. If the information is not available, indicate the reason it is not (e.g. deceased, unknown, etc.).

2. Attach all ITEMIZED BILLS (not balance due statements) for medical expenses only.

3. Include all work sheets, denial and/or statements of benefits (EOB's) from your primary carrier. Your primary carrier must process each charge before Student Athletic Protection, Inc can process it.

4. If you are employed and no coverage is provided by your employer, A LETTER OF VERIFICATION FROM YOUR EMPLOYER STATING THAT NO COVERAGE IS PROVIDED MUST BE SUBMITTED.

5. Return completed form along with itemized statement and EOB's to Mrs. Beehler at Rochester High School
   PO Box 108
   One Zebra Lane
   Rochester, IN 46975